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TESTIMONY OF DC APPLESEED FOR GHMSI SURPLUS HEARING

DC Department of Insurance, Securities and Banking
September 10, 2009

Good morning Commissioner Purcell. I am Walter Smith, Executive Director of the DC Appleseed Center. Thank you for holding this hearing and for allowing us to testify. As you know, DC Appleseed has for many years worked with your office to address the appropriate role of GHMSI in the National Capital Area. We have also worked with your counterparts in Maryland and Virginia on the issue.

Our view is that GHMSI has for several years built up excessive surpluses far beyond amounts reasonably needed to maintain its financial soundness, and that in the course of doing so it has both overcharged subscribers and underinvested in community healthcare needs. We issued a report on this in December 2004, which led to a 2005 hearing on the subject by DC Insurance Commissioner Larry Mirel; we testified in support of the legislation that has led to this hearing on the issue; and we submitted a Pre-Hearing Report to your office on August 31 laying out the basis for our view that GHMSI's current surplus is excessive and not in compliance with the legislative requirement that the company commit the "maximum feasible" amount to "community health reinvestment."

Today I would like to comment briefly on three points: (1) how we think the Commissioner should approach the surplus issue, and where we differ with GHMSI about the nature of that issue: (2) why we think it is clear that by any fair measure GHMSI's surplus is excessive; and (3) how we think the Commissioner should approach the issue of attributing a portion of GHMSI's surplus to the District. After these comments, Mr. Corwin Zass, principal of Actuarial Risk Management (ARM), who DC Appleseed engaged for the purpose of reviewing the reports submitted by CareFirst and Milliman, will also testify. Mr. Zass will outline the results of ARM's assessment, which shows that GHMSI's surplus is excessive.

1. The Excess-Surplus Issue Before the Commissioner

Let me begin by stating a point of agreement with GHMSI. GHMSI contends in its Pre-Hearing Report that the Commissioner should examine its surplus on a company-wide basis, and not attempt to first attribute a portion to each jurisdiction and then examine only the portion attributable to the District. As GHMSI says in its August 31 Pre-Hearing Report (p.27), "evaluation of the appropriateness of reserves must be performed at an entity-wide level." We agree with this point completely, and note that both Milliman and our expert examined the reserves on that basis.

But we disagree with GHMSI about how the statute requires those reserves to be evaluated. The statute requires a showing that GHMSI has committed the "maximum feasible" amount to community health reinvestment, "consistent with financial soundness and efficiency." DC Code §

31-3505.01. This requires GHMSI, as it sets surplus levels, to balance the need to maximize community health reinvestments against any further increases in surplus that would bring very marginal increases in risk reduction. This balancing becomes particularly critical as the company's surpluses continue to grow relative to its competitors and other Blues. We do not believe GHMSI has tried to apply this statutory requirement. Instead, it has simply applied the same Milliman analysis as in 2005, and that Milliman developed for a comparable company (Highmark) before the Pennsylvania Insurance Commissioner. In our view, as explained in the Covington & Burling memo, the sensible way for the Commissioner to apply the "maximum feasible" requirement is to develop a range of surplus that is adequate to protect the company's financial soundness. Because any point within the efficient range of surplus would be consistent with GHMSI's financial soundness and efficiency, GHMSI should be directed to set its target surplus toward the lower end of that range.

Our next point of disagreement with GHMSI's description of the issue here today is its contention that it has been required to limit community reinvestment "since doing too much in community giving unduly burdens subscribers as they struggle to afford their coverage." GHMSI August 31 Pre-Hearing Report at 4. It goes on to say that its "concern about subscriber expectations is especially acute in this era of rapidly rising health care costs that has left health care unaffordable for many." Id. In fact, the company contends that if it were required in this proceeding to distribute excess surplus "to the community at large," this would constitute "nothing less than a confiscation or taking of subscribers' funds at a time when subscribers – especially individuals and small groups – are struggling to pay premiums as it is." Id. at 13. For several reasons, this effort to pit "struggling subscribers" against the needs of the "community at large" is both false and ironic.

In the first place, if the Commissioner finds that the company's surplus is excessive, under the statute it is the company that must develop the plan to spend down that surplus; and under the statute the company has the authority to commit *the whole* of that plan to rate reductions for struggling subscribers or, at its discretion, to covering those who have found health insurance unaffordable. Second, as the company elsewhere admits, if it indeed has an excess surplus, this necessarily means that its subscribers "were overcharged and are due a refund." Id. at 12. In other words, the difficulty many subscribers are now facing is the result of *the company's own decisions* to build excessive surplus. And finally, if, as the company now says, any spending on community healthcare needs other than directly for subscribers amounts to "confiscation," the company has been engaging in confiscation for some time; in fact, elsewhere in its paper CareFirst touts what it calls "the disproportionately large share of community reinvestment that occurs in the District." Id. at 10. As GHMSI knows, however, spending on community health care needs that benefit the public at large, and not just subscribers, is authorized not just by the statute, but by its own federal charter. *See* Memo from DC Attorney General Robert Spagnoletti, Aug. 5, 2005 at 1.

Finally, I would like to address GHMSI's contention that "the question for the Commissioner is whether GHMSI *is doing what it can*, consistent with maintenance of an appropriate level of reserves, to safeguard the public health for the benefit of its certificate holders." GHMSI August 31 Pre-Hearing Report at 10 (emphasis added). As earlier noted, the standard in the statute is not "doing what it can"; it is committing the "maximum feasible" amount that is "consistent with financial soundness and efficiency." But having posed the question wrongly, GHMSI then answers it wrongly. It says: "The answer to that question is 'yes.' The Company's health contributions are

very substantial –running into the tens of millions of dollars each year." Id. Leaving aside the fact that GHMSI nowhere details what the "tens of millions" are and where they are spent, the fact is that the statute doesn't say the company should spend "very substantial" amounts on community reinvestments; it requires it to commit the "maximum feasible" amount.

Significantly, GHMSI contends it is spending more than its peers on community reinvestments. *See* GHMSI August 31 Pre-Hearing Report at 29. In fact, that is not so. As Deborah Chollet noted in her statement, Kaiser Permanente reported spending $28.9 million in the mid-Atlantic region on community reinvestments in 2008, equal to more than 1.5 percent of Kaiser Foundation Health Plan's gross revenue. *See* DC Appleseed Pre-Hearing Report, App. C - Chollet statement at 8. In Pennsylvania, the four BlueCross BlueShield plans annually spend 1.6 percent of gross premium revenue on community benefits. Id. If GHMSI were to spend an amount comparable to these fellow non-profits (between 1.5% and 1.6% of gross premium revenue), it would total between $46.9 and $50.0 million in 2008, instead of the $20 million that GHMSI claims to have spent. CareFirst Aug. 31 filing at 28. Furthermore, those other Blues are not subject to the "maximum feasible" standard that GHMSI is.

In the end, the only way to know if GHMSI has met the governing maximum feasible standard is to determine whether its surplus is unreasonable. As next discussed, we believe it is.

2. Determining whether GHMSI's surplus is excessive

To help us determine whether GHMSI's surplus meets the "maximum feasible" standard, we engaged the independent actuarial consulting firm, Actuarial Risk Management (ARM). Because ARM did not have access to the data, ARM proceeded to develop a reasonable range of surplus, based on GHMSI's public filings and information reported in Milliman's analysis.

As Mr. Zass explained in his statement filed with our August 31 Pre-Hearing Report, ARM found serious errors or biases, including unrealistic and unreasonable assumptions, in the Milliman analysis; however, lacking data showing all of Milliman's calculations and assumptions, ARM simply corrected for four of the most dollar-significant assumptions Milliman made: (1)ignoring the Federal Employee Program (FEP) and GHMSI's other major lines of lower-risk insured business – which caused Milliman to overstate the riskiness of GHMSI's revenues and therefore to overstate its need for surplus; (2)assuming that GHMSI needed to have excess surplus sufficient to withstand a prolonged economic downturn that bore no relationship to any of GHMSI's relevant experience – further inflating GHMSI's current need for surplus; (3)assuming also that GHMSI would experience annual premium growth rates of 12-14% even during a prolonged economic downturn, which likewise bore no relationship to the company's historic premium growth and yet further inflated its estimated need for surplus; and (4) assuming a 95% degree of certainty for avoiding the surplus falling to the 375% RBC level, where a 90% probability is more than ample. *See* DC Appleseed Pre-Hearing Report, App. B – ARM Analysis at 13-14.

Correcting only for the four errors listed above, ARM shows that instead of needing surplus in the range of 750 -1050% RBC, the company needs one in the range of 400-525%. This means that instead of its current surplus of $687 million, the company should be targeting a level toward the lower end of a 400-525% range to meet the" maximum feasible" standard–that is, $325 million,

more than $300 million below its current surplus. This lower level, as shown in the statement of Deborah Chollet filed with our August 31 Pre-Hearing Report, will bring the company more into line with its competitors. See DC Appleseed Pre-Hearing Report, App. C – Chollet statement at 5,7.

We note that Milliman used numerous other highly questionable assumptions that further increased GHMSI's apparent need for surplus. Because ARM did not correct further for these assumptions, pending access to detailed data, we believe that their conclusions are conservative with respect to the true amount of excess surplus.

Further confirming the proposition that Milliman's analysis should not be accepted is the fact that in the two most relevant precedents ---the Pennsylvania Insurance Commissioner's surplus determination, and Commissioner Mirel's surplus determination – both Commissioners rejected the Milliman analysis, even though it was virtually identical to that presented here. As we explained in our Pre-Hearing Report (*See* DC Appleseed Pre-Hearing Report, App. A, citing to PA Insurance Commissioner Determination Feb. 9, 2005), the Commissioner in Pennsylvania effectively rejected both Milliman's methodology and its suggested surplus range; and in DC, Commissioner Mirel implicitly rejected Milliman's methodology and range, saying that GHMSI could and should significantly increase its community benefits and spend down its surplus to do so. Yet, since then the company has done the opposite – it has significantly decreased its community benefits and significantly increased its surplus. *See* CareFirst Commitment Community Benefit Statement 2007; GHMSI Annual Statements.

We are aware that GHMSI has presented analysis from the Lewin Group (a wholly-owned subsidiary of United Health Group) with its August 31 Pre-Hearing Report, and contends that this analysis constitutes a "second opinion" that "confirmed" the "reasonableness of [the] range" that Milliman proposed. GHMSI August 31 Pre-Hearing Report at 6. We think a fair reading of the Lewin analysis is that it declined to confirm the specific 750-1050% RBC range calculated by Milliman. What Lewin actually says is that while "we are in agreement with the targets and the rationale," the "actual range would be a function of the assumptions" made, and "our review does not allow us to comment as to whether we would have produced the same range of surplus requirements as shown in the Milliman report." GHMSI August 31 Pre-Hearing Report, Exhibit B - Lewin at 45. In fact, Lewin says "[w]e might...differ as to the precise RBC percentage recommended." Id. at 45, 47. This is not a "second opinion" that Milliman's range is valid. Moreover, it is worth noting that in the Pennsylvania case, Lewin expressly determined that the particularly surplus ranges established by the Insurance Commissioner were "reasonable," even though the Commissioner had rejected the higher range proposed by Milliman. *See* Lewin Group, *Consideration for Regulating Surplus Accumulation and Community Benefit Activities of Pennsylvania's BlueCross and Blue Shield Plans*, June 13, 2005 at 22.

In summary, we think it is clear that Milliman's analysis should not be accepted as sufficient to demonstrate that the company is in compliance with the statute. While we believe that the Commissioner could reasonably make findings based on ARM's report, we note that the statute contemplates that the Commissioner will engage her own independent actuarial expert to assess the issue. *See* DC Code § 31-3506 (h). We encourage that she do so, and that the public be given opportunity to respond to that assessment.

This would follow the precedent Commissioner Mirel set when CareFirst attempted to convert to for-profit status. There, CareFirst proffered expert analysis showing what it said was the value of the company ($1.3 billion) and both Commissioner Mirel and Maryland Commissioner Larson engaged their own experts to determine the company's value, finding that the company had understated its value by several hundred million dollars. Eventually, it was on that basis that the conversion was denied.

We believe the stakes here are as high as they were in the conversion proceedings, and we therefore urge the Commissioner to engage her own actuarial experts to assess GHMSI's surplus and determine whether it complies with the statutory standard.

3. Determining the "attribution" issue

If the Commissioner determines that GHMSI has excess surplus, the statute contemplates that the company should be required to develop a plan to spend down the portion of the surplus that is attributable to the District. In its August 31 Pre-Hearing Report GHMSI contends that the Commissioner should determine the company's surplus attributable to the District according to the following formula: (1) determine what percentage of GHMSI's subscribers are District residents and (2) multiply GHMSI's surplus by that percentage. Using this approach, and based on GHMSI's assertion that only 11.6% of GHMSI's subscribers are District residents, GHMSI contends that only 11.6% of its surplus is attributable to the District. We completely disagree with GHMSI's approach to this issue.

In the first place, GHMSI candidly acknowledges that its attribution methodology "is a non-standard approach." GHMSI's Pre-Hearing Report at 8. The standard approach -- which is routinely followed within the insurance industry and by GHMSI itself in other circumstances -- is to attribute revenues based *not* on subscribers' residence but on the place where the contract of insurance is issued. We asked our experts to produce a set of attribution rates (as shown in the attached Exhibit A from Actuarial Risk Management) using this standard approach, and in combination with GHMSI's own publicly available data. ARM demonstrates that the portion of GHMSI's surplus attributable to the District is not 11%, but approximately 60%. This percentage substantially coincides with GHMSI's own allocation to DC for purposes of the MD premium tax.

We furthermore note that the Commissioner's own regulations for this proceeding contemplate following this standard approach, i.e., the definition of "attributable to the District" in the regulations refers to the portion of GHMSI's "operations in the District" based on "the number of policies by geographic area" and "the number of health care providers with the company by geographic area." DISB Emergency and Proposed Rulemaking § 4699.2.

In its effort to support its "residence-based" approach and thereby reduce the District's interest in GHMSI's surplus to only 11%, GHMSI appears to be making several arguments: that the company's congressional charter "supports -- indeed requires -- residency as basis for attribution" (Attachment G); that "the relevant case law mandates a residency-based approach;" and that the legislation requiring this hearing itself contemplates that residency be used as the measure for

allocating surplus (Attachment G and in a new report from Milliman labeled Exhibit A). None of these is correct.

The centerpiece of GHMSI's proposed attribution method appears to be based on a misreading of the statute. Milliman argues in its new report that "the intent of the legislation is to have any distribution of surplus ...benefit [only] residents of the District of Columbia. It was our conclusion based on this understanding that the residence method is the appropriate alternative." Milliman's Report dated August 28, 2009 at 40.

But this is not what the statute says. What the statute actually says is: "if the Commissioner determines that the surplus of the corporation is excessive, the Commissioner shall order the corporation to submit a plan for dedication of the excess to community health reinvestment in a fair and equitable manner." DC Code § 31-3506(g)(1). The statute also says that "the plan" may "consist entirely of expenditures for the benefits of current subscribers of the corporation." Id. at (2). Nothing in the statute supports what seems to be the entire premise of Milliman's residence-based theory, i.e., that only District residents may benefit from any distribution of the District's allocated share of the surplus. Indeed, the statute actually directs that in the implementation of the act "the Commissioner shall consider the interests and needs of the jurisdictions in the corporation service area." DC Code § 31-3506.01 (2).

Furthermore, the contentions in GHMSI's Attachment G that either the federal charter itself or the relevant case law requires a residence-based approach are also unfounded. As explained in the attached memorandum from Covington & Burling (Exhibit B), the charter and relevant case law if anything, confirm that the standard attribution approach -- attributing revenue to the jurisdiction where the insurance contract is issued -- is appropriate here.

Nevertheless, as the DISB considers this issue, we urge that you decline GHMSI's invitation to play the jurisdictions against each other, and instead, as part of your process in formulating your own order, work closely with the Commissioners in the other jurisdictions to encourage a plan of distribution for the excess surplus that will fairly and equitably benefit subscribers and residents throughout the National Capital Area. We believe that such a plan could take into account the numbers of contracts, healthcare providers, and residents within a given jurisdiction, and the amount of employer contributions and health care needs within each jurisdiction. We also urge you to recognize that many healthcare benefits that the company could and should be providing will simultaneously improve the lives of citizens and subscribers in all three jurisdictions. In the end, GHMSI's effort to balkanize this process -- by insisting that the District must benefit only District residents and that Maryland and Virginia must do the same -- is not only contrary to the governing statute; it also ill-serves all three jurisdictions' common interest in ensuring that GHMSI meet its charitable and benevolent obligation throughout the entire region.

Thank you. I would be happy to answer any questions you have.